Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED							
			A. BOILDING.		F							
		HAL034009	B. WING			3/2016						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
SHULER HEALTH CARE/CRANE VILLA 250 PITT STREET KERNERSVILLE, NC 27284												
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE						
{C 000}	{C 000} Initial Comments											
	Miller on May 3, 20											
	Follow-Up Construc	encies cited during the ction Survey, have not been cted and will require a new										
{C 164}	Housekeeping and	Furnishings-Clean, Repaired	{C 164}									
	FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture of	06 HOUSEKEEPING AND										
		et as evidenced by: vation, some building not maintained in clean,										
	vents and their ass covered with dust a	2016: eas still had HVAC return ociated radiation dampers and dirt, which could interfere tivating properly in a fire										
{C 189}	Building Equipment	t Maintained Safe, Operating	{C 189}									
	SECTION .0300 - F 10A NCAC 13F .03											

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED							
			71. BOILDING.	••	F	₹						
		HAL034009	B. WING			3/2016						
NAME OF PROVIDER OR SU	JPPLIER			STATE, ZIP CODE								
SHULER HEALTH CARE/CRANE VILLA 250 PITT STREET KERNERSVILLE, NC 27284												
PREFIX (EACH DE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLE DATE								
mechanical, care home soperating comperating comperating comperating comperations with the fire shall recomperation of the fire shall recomperation of the fire shall recompartments. This would a smoke and for compartments findings on New Citation of the comperation of the sunder the sunder the sunder the sunder the shall recomperate the shall recompe	ENTS ding ar and plandition e shall a the exponent a safetance of the control of	and all fire safety, electrical, cumbing equipment in an adult maintained in a safe and apply to new and existing acception of Paragraph (e) ally to existing facilities. Let as evidenced by: vation, the building was not be manner by not maintaining rating of building components. Il residents by not containing the room or smoke gin.	{C 189}									

Division of Health Service Regulation STATE FORM